

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041830</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>HEARTLAND HEALTH CARE CTR-MOLINE</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>833 16th Avenue</u> <u>Moline</u> <u>61625</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Rock Island</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Barry Lazarus</u> (Title) <u>Vice-President Reimbursement</u>	
Telephone Number: <u>(309)764-6744</u> Fax # <u>(309)764-8176</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()	
IDPA ID Number: <u>344402510012</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>1966</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Craig Dekany</u> Telephone Number: <u>(419) 252-5740</u>			

STATE OF ILLINOIS

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Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MOLINE# 0041830 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>139</u>	Skilled (SNF)	<u>139</u>	<u>50,735</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>139</u>	TOTALS	<u>139</u>	<u>50,735</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>0</u>	<u>1,791</u>	<u>5,371</u>	<u>7,162</u>	8
9	SNF/PED					9
10	ICF	<u>4,888</u>	<u>37,710</u>	<u>109</u>	<u>42,707</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,888</u>	<u>39,501</u>	<u>5,480</u>	<u>49,869</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 98.29%

D. How many bed-hold days during this year were paid by Public Aid?

49 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/83

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 10/16/95 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 21 and days of care provided 5,274Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MOLI # 0041830 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	230,270	15,577	2,048	247,895	1,954	249,849		249,849		1
2	Food Purchase		225,357		225,357		225,357	(2,411)	222,946		2
3	Housekeeping	124,247	14,415	681	139,343		139,343		139,343		3
4	Laundry	63,002	13,927	693	77,622		77,622		77,622		4
5	Heat and Other Utilities			125,796	125,796	7,963	133,759	(6,492)	127,267		5
6	Maintenance	36,908	8,148	15,916	60,972		60,972		60,972		6
7	Other (specify):* Med Waste			531	531		531		531		7
8	TOTAL General Services	454,427	277,424	145,665	877,516	9,917	887,433	(8,903)	878,530		8
	B. Health Care and Programs										
9	Medical Director			10,500	10,500		10,500		10,500		9
10	Nursing and Medical Records	1,787,835	151,787	12,325	1,951,947	33,923	1,985,870		1,985,870		10
10a	Therapy	196,259	1,810	12,187	210,256		210,256		210,256		10a
11	Activities	118,938	7,819	817	127,574		127,574		127,574		11
12	Social Services	70,015	802	761	71,578		71,578		71,578		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,173,047	162,218	36,590	2,371,855	33,923	2,405,778		2,405,778		16
	C. General Administration										
17	Administrative	102,562		332,998	435,560	(143,406)	292,154		292,154		17
18	Directors Fees										18
19	Professional Services			360	360		360	(360)			19
20	Dues, Fees, Subscriptions & Promotions			54,726	54,726		54,726	(45,530)	9,196		20
21	Clerical & General Office Expenses	135,526	36,325	33,072	204,923		204,923	(27,271)	177,652		21
22	Employee Benefits & Payroll Taxes			535,224	535,224	60,999	596,223		596,223		22
23	Inservice Training & Education			1,470	1,470		1,470		1,470		23
24	Travel and Seminar			16,850	16,850		16,850		16,850		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			113,087	113,087		113,087		113,087		26
27	Other (specify):*			724	724		724		724		27
28	TOTAL General Administration	238,088	36,325	1,088,511	1,362,924	(82,407)	1,280,517	(73,161)	1,207,356		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,865,562	475,967	1,270,766	4,612,295	(38,567)	4,573,728	(82,064)	4,491,664		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MOLINE #0041830 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			440,590	440,590	38,567	479,157		479,157			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			65,194	65,194		65,194		65,194			32
33	Real Estate Taxes			107,537	107,537		107,537	26,091	133,628			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,490	4,490		4,490		4,490			35
36	Other (specify):*											36
37	TOTAL Ownership			617,811	617,811	38,567	656,378	26,091	682,469			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		357,614	10,863	368,477		368,477		368,477			39
40	Barber and Beauty Shops			23,669	23,669		23,669		23,669			40
41	Coffee and Gift Shops	115,096			115,096		115,096		115,096			41
42	Provider Participation Fee			76,103	76,103		76,103		76,103			42
43	Other (specify):*		5,143		5,143		5,143		5,143			43
44	TOTAL Special Cost Centers	115,096	362,757	110,635	588,488		588,488		588,488			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,980,658	838,724	1,999,212	5,818,594		5,818,594	(55,973)	5,762,621			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **HEARTLAND HEALTH CARE CTR-MOLINE**# **0041830**Report Period Beginning: **01/01/02**Ending: **12/31/02****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,411)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,492)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(33)	21		10
11	Discounts, Allowances, Rebates & Refunds	(2)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,068)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(852)	21		16
17	Non-Care Related Fees	(5,517)	21		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,608)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(360)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,191)	21		24
25	Fund Raising, Advertising and Promotional	(45,530)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	26,091	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (55,973)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (55,973)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
HEARTLAND HEALTH CARE CTR-MOLINE

Page 5A

ID# 0041830
Report Period Beginning: 01/01/02
Ending: 12/31/02

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MOLINE

0041830

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,411)	0	0	0	0	0	0	0	0	0	0	(2,411)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(6,492)	0	0	0	0	0	0	0	0	0	0	(6,492)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,903)	0	0	0	0	0	0	0	0	0	0	(8,903)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(360)	0	0	0	0	0	0	0	0	0	0	(360)	19
20	Fees, Subscriptions & Promotions	(45,530)	0	0	0	0	0	0	0	0	0	0	(45,530)	20
21	Clerical & General Office Expenses	(27,271)	0	0	0	0	0	0	0	0	0	0	(27,271)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(73,161)	0	0	0	0	0	0	0	0	0	0	(73,161)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(82,064)	0	0	0	0	0	0	0	0	0	0	(82,064)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MOLINE

0041830

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	26,091	0	0	0	0	0	0	0	0	0	0	26,091	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	26,091	0	0	0	0	0	0	0	0	0	0	26,091	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(55,973)	0	0	0	0	0	0	0	0	0	0	(55,973)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O Cost Report)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	See	Home Office Allocation	\$ 332,998	HCR Manor Care, Inc.	100.00%	\$ 332,998	\$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	12,000	Heartland Management Services	100.00%	12,000		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 344,998			\$ 344,998	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MOI # 0041830 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MOLINE # 0041830 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HCR Manor Care, Inc.
 Street Address 333 North Summit St.
 City / State / Zip Code Toledo, OH. 43604
 Phone Number (419)252-5500
 Fax Number (419)254-5494

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	\$ 0	\$	5,684,521	\$ 0	1
2	1 Dietary - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	920,912	536,824	5,684,521	1,954	2
3	5 Utilities - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	112,862		5,684,521	283	3
4	5 Utilities - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	3,618,915		5,684,521	7,680	4
5	10 Nursing - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	11,131,912	7,408,777	5,684,521	27,890	5
6	10 Nursing - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	2,842,925	1,812,855	5,684,521	6,033	6
7	17 General & Admin - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	19,326,083	15,188,841	5,684,521	48,419	7
8	17 General & Admin - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	66,522,981	38,146,902	5,684,521	141,172	8
9	22 Employee Benefits - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	2,749,439		5,684,521	6,888	9
10	22 Employee Benefits - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	25,498,075		5,684,521	54,111	10
11	30 Depreciation - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	148,355		5,684,521	372	11
12	30 Depreciation - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	17,998,306		5,684,521	38,196	12
13									13
14	32 Interest				7,352,132			0	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 158,222,897	\$ 63,094,199		\$ 332,998	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank of America		X	Purchase Facility		Oct-91	\$ 389,893	\$ 389,893			\$ 10,712	1	
2	Bank of America		X	Finance Capital Additions		Mar-97	869,574	869,574			23,891	2	
3	Bank of America		X	Finance Capital Additions		Nov-97	102,930	102,930			2,828	3	
4	Bank of America		X	Finance Capital Additions		June-01	899,646	899,646			24,717	4	
5	Bank of America		X	Finance Capital Additions		Sept.-01	110,901	110,901			3,046	5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 2,372,944	\$ 2,372,944			\$ 65,194	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,372,944	\$ 2,372,944			\$ 65,194	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

12/31/02

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HEARTLAND HEALTH CARE CTR-MOLINE COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0041830

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-533-28-00</u>	<u>See Attached</u>	\$ <u>107,537</u>	\$ <u>107,537</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>107,537.00</u>	\$ <u>107,537.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet:

43,321

B. General Construction Type:

Exterior

Masonry

Frame

Steel, Fire Resistant

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1983	\$ 74,186	1
2			1996	106,824	2
3	TOTALS			\$ 181,010	3

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MOLINE

0041830

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	119	1966	1966	\$ 1,033,964	\$	30	\$	\$	\$ 1,033,964
5			1983	56,519		5			56,519
6	10		1998	1,398,475	77,980	10-20	77,980		377,554
7	10		2002	709,498	16,259	40	16,259		16,259
8									
Improvement Type**									
9	Building Improvements (Current Year Depreciation)				248,291		248,291		1,242,817
10	Leasehold Improvements		1971	26,975					
11	Leasehold Improvements		1972	1,481					
12	Leasehold Improvements		1973	2,593					
13	Leasehold Improvements		1974	271					
14	Leasehold Improvements		1975	4,140					
15	Leasehold Improvements		1976	16,237					
16	Leasehold Improvements		1977	10,225					
17	Leasehold Improvements		1978	5,160					
18	Leasehold Improvements		1981	28,386					
19	Leasehold Improvements		1982	14,373					
20	Leasehold Improvements		1983	22,737					
21	Leasehold Improvements		1984	5,789					
22	Land Improvements		1985	1,470					
23	Building Improvements		1985	109,949					
24	Building Improvements		1986	25,262					
25	Building Improvements		1987	16,145					
26	Land Improvements		1987	707					
27	Building Improvements		1988	204,870					
28	Building Improvements		1989	3,273					
29	Building Improvements		1990	22,292					
30	Building Improvements		1991	8,230					
31	Land Improvements		1991	4,771					
32	Building Improvements		1992	16,985					
33	Building Improvements		1993	21,450					
34	Building Improvements		1994	51,438					
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38	Land Improvements	1995	980						38
39	Building Improvements	1995	32,598						39
40	Land Improvements: Sign, Landscaping, and Concrete Bumpers	1996	25,027						40
41	Building Improvements: Painting/Wallcovering, Carpet, Paving system,	1996	126,134						41
42	doors/fixtures,millwork,air conditioning, moving/storage, cabinets,								42
43	hand rails,electrical wiring, ceramic tile, and bathroom sinks								43
44	Building Improvements: Fire alarm	1996	45,151						44
45	Building Improvements: Intercom system	1996	27,230						45
46	Building Improvements: Renovation of lobby, foyer, busines office:	1996	94,414						46
47	architect and engineering fees, interior design costs, drywall and								47
48	corner guards, aluminum chips, electrical heating, air conditioning								48
49	fire stop installation and access doors, and storage fees								49
50	Building Improvements: Wallcovering	1996	118,024						50
51	Building Improvements: Sewer Runs	1997	10,708						51
52	Building Improvements: Wallcovering, Floor Carpet, Cabinets,	1997	120,159						52
53	door frames, millwork, carpetry, caulking, ceilings plaster,								53
54	plumbing comosite, electrical composite, sinks, conduit wiring,								54
55	door closing devices, nurses call system								55
56	Building Improvements: 18 Bed Addition, wallcovering, conncrete,	1997	334,930						56
57	doors wood, telephone system, fencing wire, electrical transformer,								57
58	HVAC, hollow metal doors, duct work								58
59	Building Improvements: Install HVAC, electrical composite	1997	291,760						59
60	Building Improvements: Roof Replacement	1997	49,483						60
61	Building Improvements: Door	1997	1,042						61
62	Building Improvements: Siding on new additon	1997	4,993						62
63	Building Improvement: VWC from Inventory	1997	1,464						63
64	Land Improvements: Sign	1997	593						64
65	Land Improvements: Landscaping	1997	801						65
66	Land Improvements: Fence	1997	5,422						66
67	Bldg. Improvements: Cupola	1998	5,440						67
68	Bldg. Improvements: HVAC	1998	23,069						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,143,087	\$ 342,530		\$ 342,530	\$	\$ 2,727,113	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,143,087	\$ 342,530		\$ 342,530	\$	\$ 2,727,113	1
2									2
3	Bldg. Improvements: Roof	1998	8,203						3
4	Bldg. Improvements: Electrical Work for Renovation	1998	32,459						4
5	Bldg. Improvements: Add't HVAC	1998	15,464						5
6	Bldg. Improvements: 8 Bed Addition	1998	88,423						6
7	Building Improvements: Light Fixtures for Nurses Station	1998	2,211						7
8	Land Improvements: Grading	1998	1,779						8
9	Bldg. Improvements: Wall covering, charting system, compressor	1998	35,511						9
10	Bldg. Improvements: Doors	1998	10,151						10
11	Asphalt Work	1999	14,164						11
12	Smoking Shelter	1999	5,254						12
13	Overhead from Const	1999	29,447						13
14	Concrete Pad for Smoking	1999	924						14
15	Exit Device	1999	474						15
16	Carpet	1999	994						16
17	Carpet	1999	553						17
18	Awning	1999	2,788						18
19	Building Decorations	1999	653						19
20	Retainage for Carpet	1999	73						20
21	Retainage Fee for Carpet	1999	59						21
22	Wallboard	1999	568						22
23	Wiring	1999	3,850						23
24	Wall, Drain Lines, Electrica	1999	15,776						24
25	Boiler Pump	2000	5,433						25
26	HVAC Upgrade	2000	1,600						26
27	Boiler room exhaust	2000	5,684						27
28	Phone line	2000	800						28
29	Phone line	2000	800						29
30	Ceramic tile	2000	511						30
31	Carpet	2000	842						31
32	Sinks & faucet	2000	1,055						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,429,587	\$ 342,530		\$ 342,530	\$	\$ 2,727,113	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,429,587	\$ 342,530		\$ 342,530		\$ 2,727,113	1
2									2
3	Add'l cost sinks	2000	218						3
4	Add'l cost carpeting	2000	59						4
5	Add'l cost carpet	2000	94						5
6	Retainer on boiler room exhaust	2000	632						6
7	Replace door in laundry	2000	4,932						7
8	Bldg Imprv - Carpentry/Wallcovering	2001	11,535						8
9	Bldg Imprv - Carpentry/Electrical	2001	60,645						9
10	Bldg Imprv - Wallcovering	2001	11,630						10
11	Land Imprv - Concrete work	2001	4,941						11
12	Land Imprv - Walkway & Canopy	2001	3,858						12
13	Wire Component Connection	2001	2,543						13
14	Wire Component Connection	2002	327						14
15	Wire Component Connection	2002	402						15
16	Building Addition - VWC - Corridor	2002	19,847						16
17	Paint, VWC - Corridor Renovation	2002	45,377						17
18	Corner Guards	2002	7,153						18
19	Mini-Edger	2002	729						19
20	Corner Guards - Asset adjustment	2002	(4,953)						20
21	Building Addition - Paving/Landscaping	2002	8,679						21
22	Building Addition - Paving/Landscaping	2002	8,397						22
23	Building Addition - Paving/Landscaping	2002	111,907						23
24	Paving	2002	5,025						24
25	Dell (2) Celeron	2002	1,687						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,735,250	\$ 342,530		\$ 342,530		\$ 2,727,113	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,453,559	\$ 98,060	\$ 98,060	\$		\$ 1,029,201	71
72	Current Year Purchases	77,969						72
73	Fully Depreciated Assets							73
74	Home Office Allocation		38,567	38,567				74
75	TOTALS	\$ 1,531,528	\$ 136,627	\$ 136,627	\$		\$ 1,029,201	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Residents	1986 Chevy Van With		\$ 22,049	\$	\$	\$		\$ 22,049	76
77		Chair Lift								77
78										78
79										79
80	TOTALS			\$ 22,049	\$	\$	\$		\$ 22,049	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,469,837	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 479,157	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 479,157	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,778,363	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ 4,490 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ _____

13. /2004 \$ _____

14. /2005 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2	3	4
		Facility				
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10A	2521	hrs	\$ 60,295	184	\$ 4,606	\$ 367	2,705	\$ 65,268	1
2	Licensed Speech and Language Development Therapist	10A	1295	hrs	30,964	62	1,560	144	1,357	32,668	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A	4390	hrs	105,000	237	5,931	1,299	4,627	112,230	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescripts				357,614		357,614	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							
10				hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): P/S X-Ray,Lab	10a,39,Col.3					10,953			10,953	13
14	TOTAL				\$ 196,259	484	\$ 23,050	\$ 359,424	8,690	\$ 578,733	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 632	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 41,707)	548,181		3
4	Supply Inventory (priced at)	6,031		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,318		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 556,162	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	181,010		13
14	Buildings, at Historical Cost	5,733,562		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,553,578		16
17	Accumulated Depreciation (book methods)	(3,776,676)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,691,474	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,247,636	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 41,002	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	260,405		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	107,537		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	50,459		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 459,403	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,372,944		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,372,944	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,832,347	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,415,289	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,247,636	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 822,634	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 822,634	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,616,507	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,616,507	17
	B. Transfers (Itemize):		
18	Change In Interdivision	(2,023,852)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,023,852)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,415,289	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MOLINE # 0041830 Report Period Beginning: 01/01/02

Ending: 12/31/02

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,440,871	1
2	Discounts and Allowances for all Levels	(67,229)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,373,642	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	596,288	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 596,288	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,574	12
13	Barber and Beauty Care	28,281	13
14	Non-Patient Meals	689	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	373,588	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,599	19
20	Radiology and X-Ray	2,738	20
21	Other Medical Services	6,150	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 459,619	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,517	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,517	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	35	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 35	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,435,101	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	877,516	31
32	Health Care	2,371,855	32
33	General Administration	1,362,924	33
	B. Capital Expense		
34	Ownership	617,811	34
	C. Ancillary Expense		
35	Special Cost Centers	588,488	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,818,594	40
41	Income before Income Taxes (line 30 minus line 40)**	2,616,507	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,616,507	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MOLINE

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Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,812	1,978	\$ 51,483	\$ 26.03	1
2	Assistant Director of Nursing	3,520	3,842	73,120	19.03	2
3	Registered Nurses	11,895	12,984	233,735	18.00	3
4	Licensed Practical Nurses	29,472	32,169	464,730	14.45	4
5	Nurse Aides & Orderlies	90,936	99,258	930,714	9.38	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,339	8,171	195,452	23.92	7
8	Rehab/Therapy Aides	80	80	807	10.09	8
9	Activity Director	11,498	12,547	118,938	9.48	9
10	Activity Assistants					10
11	Social Service Workers	3,897	4,251	70,015	16.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,820	27,138	230,270	8.49	15
16	Dishwashers					16
17	Maintenance Workers	2,054	2,240	36,908	16.48	17
18	Housekeepers	14,372	15,684	124,247	7.92	18
19	Laundry	6,630	7,234	63,002	8.71	19
20	Administrator	3,008	2,080	102,562	49.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,589	21,033	250,622	11.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,947	2,125	34,053	16.02	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	231,869	252,814	\$ 2,980,658 *	\$ 11.79	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 1,142	5,1,3	35
36	Medical Director	Monthly	10,500	5,9,3	36
37	Medical Records Consultant	Monthly	360	5,10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,325	5,10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	761	5,11,3	44
45	Social Service Consultant	Monthly	761	5,12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,849		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications

****See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)**

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$6,197
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 61,410 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Moline Nurs & Rehab Center #33084 Transferred to HCR of America 8/15/96
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 76,103
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 689
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.